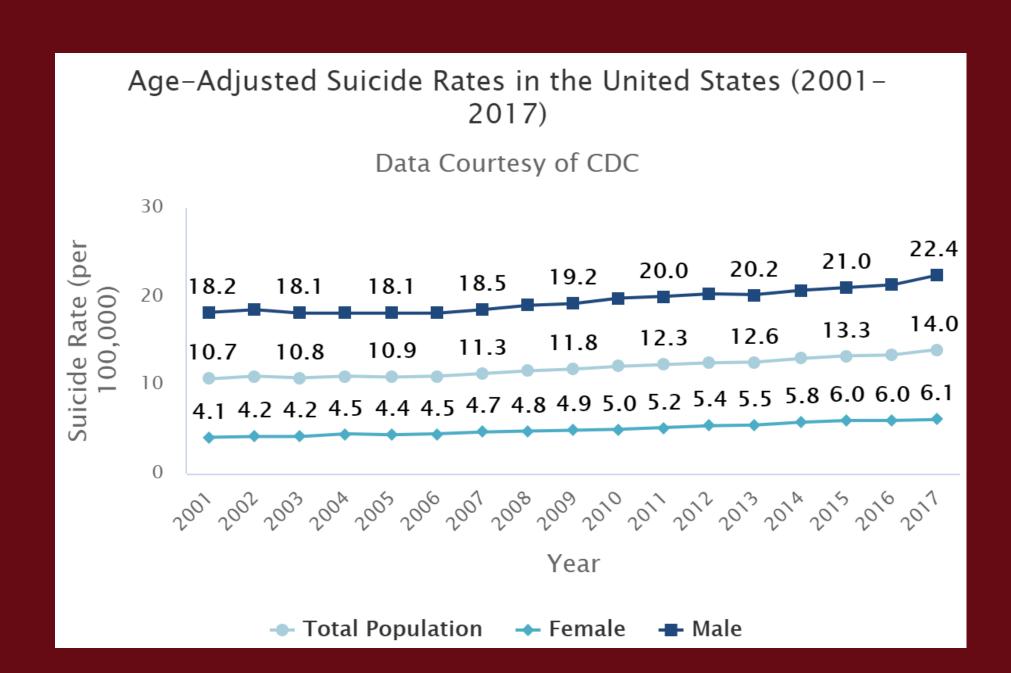
Suicidality in adolescents

ADOLESCENT SUBSTANCE USE ECHO

MAY 22, 2019

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Warning signs of suicide

- Obsession with death or frequent conversations about death
- Direct or indirect threats of suicide
- Hints about life not worth living "hopeless", "helpless", "I shouldn't be here", "it'd be better off if I wasn't around"
- Intense and overwhelming guilt, shame, rejection
- Sudden mood improvement after period of depression that is out of the ordinary for individual

Increased irritability

- Changes in eating or sleeping
- Changes in personality or demeanor
- Changes in school performance or involvement in other extracurricular activities
- Putting affairs in order (getting rid of important possessions)



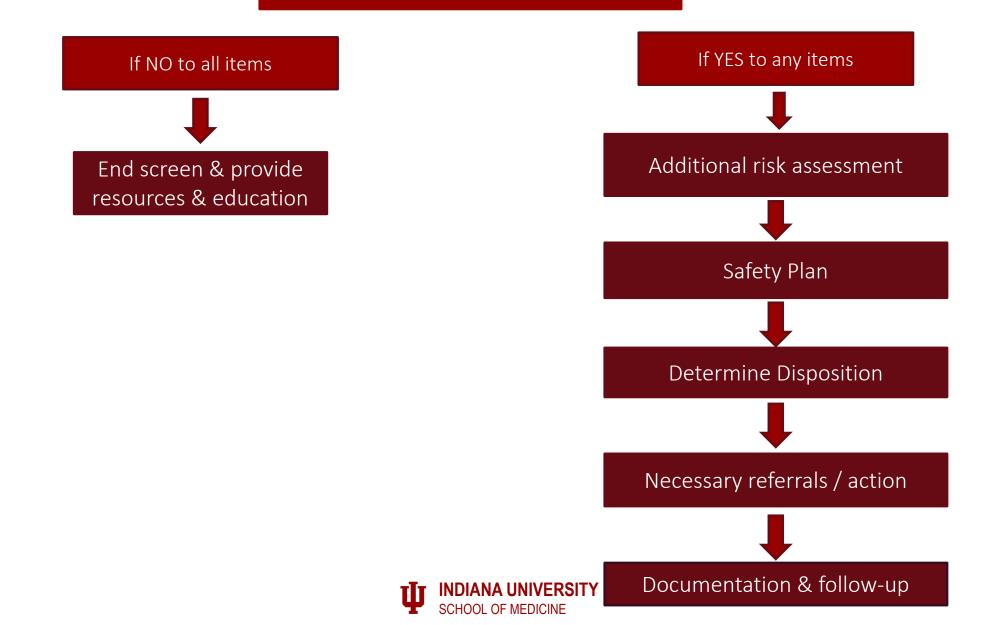
When should I screen for suicide risk?

- Myth: asking about suicide gives an individual thoughts / ideas
- Suicide screening should be routine!
 - Preventative
 - Models to parents about discussing with youth
 - Demonstrates to youth that it's OK to talk about it





Initial suicide risk screen



Initial suicide risk screen

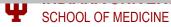
asQ		
Ask Suicide-Screening Questions		
Ask the patient:		
 In the past few weeks, have you wished you were dead? 	Yes	No
In the past few weeks, have you felt that you or your family would be		
better off if you were dead?	Yes	No
3. In the past week, have you been having thoughts about killing yourself?	Yes	No
4. Have you ever tried to kill yourself?		No
If yes, how?When?		
If the patient answers yes to any of the above, ask the following question:		
5. Are you having thoughts of killing yourself right now?	Yes	No
If yes, please describe:		National Institute of Mental Health

SCHOOL OF MEDICINE

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Additional suicide risk assessment

1. Praise Patient	\cdot Validate them for sharing
2. Assess with patient alone	 Ideation: frequency, intensity, duration, note if current ideation (i.e., within past 48 hours) Suicide plan, intent, previous behaviors/attempts Warning signs: changes in sleep/appetite, mood, isolation, etc. Risk factors: recent break-up or loss, family conflict, significant life change, family history, recent hospital discharge
3. Assess with parent & patient	 Share with parent Re-assess warning signs, risk factors with parent report
4. Safety Plan (NOT safety contract)	 Identify people they will tell if having thoughts Identify coping strategies Determine means restriction (removal of firearms access, medications, other lethal items) Ask patient: Do you think you need help to keep yourself safe?



Intervention	Risk & Protective Factors	Suicidality
ED referral	 Acute psychiatric symptoms, acute precipitating event NO current mental health provider Patient/parent doesn't feel they can stay safe 	 Current and/or intense ideation with plan and intent Past suicide behavior or attempt
Immediate mental health referral or connection to provider	 Non-acute psychiatric symptoms Safety plan with coping strategies & contacts identified 	 Suicidal ideation with plan but no intent or behavior
Non-urgent mental health referral / follow- up	 Safety plan in place Risk factors modifiable Few warning signs 	 Thoughts of death, no plan, intent, or behavior



Provider Resources

- NIMH asQ Suicide toolkit
 - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml
- Suicide Resource Prevention Center
 - https://www.sprc.org/
- SAMHSA suicide resources
 - https://www.samhsa.gov/find-help/suicide-prevention



Patient / Parent Resources

- National Suicide Prevention Lifeline
 - 1-800-273-TALK (8255)
- 24/7 Crisis Text Line
 - Text "HOME" to 741-741
- Covenant House Nine Line
 - 1-800-999-9999

